GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2008 Freestanding Ambulatory Surgery Center Survey

Part A : General Information

1. Identification

UID:ASC053

Facility Name: Endoscopy Center of Columbus, LLC

County: Muscogee

Street Address: 1130 Talbotton Road

City: Columbus

Zip: 31904

Mailing Address: 1130 Talbotton Road

Mailing City: Columbus

Mailing Zip: 31904

2. Report Period

Report Data for the full twelve month period, January 1, 2008 - December 31, 2008 (365 days).
Do not use a different report period.

Check the box to the right if your facility was **not** operational for the entire year. ☐
If your facility was **not** operational for the entire year, provide the dates the facility was operational.

Part B : Survey Contact Information

Person authorized to respond to inquiries about the responses to this survey.

Contact Name: Pravinchandra H. Patel, M.D.

Contact Title: CEO- President

Phone: 706-641-6900

Fax: 706-327-0757

E-mail: gdicolumbus@hotmail.com

Part C : Ownership, Operation and Management

1. Ownership, Operation and Management

As of the last day of the report period, indicate the name of the legal entities which own/operate the facility if applicable or the name of the physician(s) in ownership of the center. Using the drop-down menus, select the organization type. If the category is not applicable, the form requires you only to enter Not Applicable in the legal name field. You must enter something for each category.

A. Facility Owner

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
ECC Holdings, Inc and Shankar Thiruppathi, M.D.	For Profit	10/17/2008

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Gastrointestinal Diseases, Inc	For Profit	01/25/1996

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
ECC Holdings, Inc and Shankar Thiruppathi, M.D.	For Profit	10/17/2008

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Gastrointestinal Diseases, Inc	For Profit	01/25/1996

E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
	NA	

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
	NA	

G. Physician Owner(s) *(List all if owned jointly)*

Full Name	License Number
Ashwinkumar D. Patel, MD	38326
Shankar Thiruppathi, MD	58022
Pravinchandra H. Patel, MD	27888

Part D : Ambulatory Surgery Rooms, Procedures and Patients

1A. Rooms, Procedures and Patients in CON-Authorized or Licensed Operating Procedure Rooms

An operating procedure room is a procedure room or area of the ambulatory surgical treatment center in which surgical procedures are performed and that is licensed as a procedure room by the Department of Human Resources pursuant to Rule 290-5-33-01(u).

Room Type	Number of Rooms	Number of Procedures	Number of Patients
Operating Procedure Rooms	2	3,834	3,778

1B. Other Nonoperating/Procedure Rooms

If applicable, provide rooms, procedures and patients for other rooms at your facility where procedures are performed, but that are not licensed as operating rooms.

Room Type	Number of Rooms	Number of Procedures	Number of Patients
Endoscopy Procedure Rooms	0	0	0
Minor Procedure Rooms	0	0	0
Other Procedure Rooms	0	0	0

2. Ambulatory Surgery Patients Admitted to Hospital

How many patients if any, were admitted to a hospital before completion of or immediately following ambulatory surgery?

0

3. Ambulatory Patients by Race/Ethnicity

Report the number of unduplicated patients who received ambulatory surgery by race/ethnicity category and provide the total number of ambulatory surgical procedures by race/ethnicity.

Race/Ethnicity	Number of Patients	Number of Procedures
American Indian/Alaska Native	0	0
Asian	76	82
Black/African American	1,625	1,645
Hispanic/Latino	113	118
Pacific Islander/Hawaiian	1	2
White	1,587	1,606
Multi-Racial	0	0
Unknown	376	381
Total	**3,778**	**3,834**

4. Ambulatory Patients by Gender

Report the number of patients by gender served during the report period along with the total number of procedures by gender.

Gender	Number of Patients	Number of Procedures
Male	1,490	1,512
Female	2,288	2,322
Total	**3,778**	**3,834**

Part E : Ambulatory Surgical Procedures, Licensed Specialty and Services

1. Top Ten Procedures

Of the total procedures reported in Part D, provide the top ten procedures (volume-wise) performed within your facility by CPT Code, Procedure Name, Number of Procedures and Average Charge for Procedure.

CPT Code	Procedure Name	Number of Procedures	Average Charge
45378	Colonoscopy	1,049	1,175.00
43239	EGD with biopsy	896	1,075.00
45385	Colonoscopy with polypectomy	345	1,525.00
43235	EGD	444	875.00
45380	Colonoscopy with biopsy	309	1,275.00
45330	Flex Sig	88	400.00
43248	EGD with dilation	73	1,075.00
45331	Flex Sig with biopsy	42	500.00
43251	EGD with polypectomy	28	1,175.00
45333	Flex Sig with polypectomy	13	875.00

2. Licensed Specialty and Services Provided

Report the licensed specialty of the ambulatory surgery center and the services provided.

Specialty(ies)*(As indicated on the Office of Regulatory Services permit)*:

Gastrointestinal

Services Provided:

Endoscopy

Part F : Utilization & Revenue by Payer Source for Ambulatory Surgery Services

1. Utilization by Payer Source

Please report the number of patients and procedures, Gross Patient Revenue, and Net Patient Revenue during the report period according to Payer Source. Please note that the Total Gross and Net Revenue columns should balance to Gross and Net Revenue reported in Part G.

Payer Source	Patients	Procedures	Gross Revenue	Net Revenue
Medicare	1,424	1,445	1,667,896	574,011
Medicaid	355	355	409,759	141,020
PeachCare for Kids	0	0	0	0
Third Party	1,911	1,946	2,246,171	773,029
Self Pay	12	12	13,851	4,767
Other Payer	76	76	87,723	30,190
Total	**3,778**	**3,834**	**4,425,400**	**1,523,017**

2. Indigent/Charity Care

Provide the number of ambulatory surgery patients and procedures for patients who were income tested as indigent or charity care cases. Refer to the definitions of indigent and charity care in the instructions.

Category	Number of Patients	Number of Procedures
Indigent	33	33
Charity	48	48
Total	**81**	**81**

Part G : Financial Summary and Indigent and Charity Care Information

1. Indigent and/or Charity Care Policy

Check the box to the right if the agency had a formal written policy or written policies concerning the provision of indigent and/or charity care during 2008. ☑

If you indicated yes above, please indicate the effective date of the policy or policies.

01/25/1996

2. Person Responsible

Please indicate the name and title or position held by the person most responsible for adherence to or interpretation of the policy or policies you will provide the department.

Pravinchandra H. Patel, MD

3. Charity Care Provision

Check the box if the policy or policies included provision for the care that is defined as charity. ☑

4. Financial Table

Please complete the following financial table for the 2008 calendar year. Please not that Total Uncompensated Indigent and Charity Care Charges (automatically calculated by the web form) should not exceed Gross Indigent and Charity Care Charges.

Revenue or Expense	Amount
Gross Patient Revenue	4,425,400
Medicare Contractual Adjustments	1,189,671
Medicaid Contractual Adjustments	253,752
Other Contractual Adjustments	1,309,397
Total Contractual Adjustments	**2,752,820**
Bad Debt	56,986
Indigent Care Gross Charges	42,225
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	**42,225**
Charity Care Gross Charges	50,352
Charity Care Compensation	0
Uncompensated Charity Care (Net)	**50,352**
Other Free Care	0
Total Net Patient Revenue	**1,523,017**
Other Revenue	0
Total Net Revenue	**1,523,017**
Total Expenses	0
Adjusted Gross Revenue	**2,924,991**
Total Uncompensated I/C Care	**92,577**
Percent Uncompensated Indigent/Charity Care	**3.17%**

Part H : Accreditation

Indicate below if your ambulatory surgery center is accredited and if so indicate for each agency as applicable.

A) American Association of Ambulatory Care? ☐

B) American Association for Accreditation of Plastic Surgery Facilities? ☐

C) Joint Commission for Accreditation of Healthcare Organizations (JCAHO)? ☐

D) Accreditation Association for Ambulatory Health Care (AAAHC)? ☑

E) Accreditation Association for Ambulatory Health Care (AAAHC)? ☐

F) Other? ☐
Specify other organizations that accredit your facility in the space below.

Part I : Patient Origin of Ambulatory Surgery Patients in the Surgical Center

1 Patient Origin

Please report the county of origin for the patients treated in the surgical center.

County	Patients
Chattahoochee	25
Clarke	1
Cook	3
Harris	264
Lee	216
Macon	1
Marion	62
Meriwether	14
Muscogee	2267
Other- Out of State	737
Peach	1
Quitman	3
Randolph	6
Schley	4
Seminole	2
Stewart	49
Sumter	27
Talbot	51
Taylor	10
Treutlen	23
Upson	3
Webster	9
Total	**3,778**

Part J : Ambulatory Surgery Center Workforce Information

1. Budgeted FTE

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2008.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Registered Nurses (RNs Advanced Practice)	4	0	0
Licensed Practical Nurses (LPNs)	0	0	0
Aides/Assistants	5	0	0
Allied Health Therapists	0	0	0

2. Filling Vacancies

Please enter the average time needed during the past six months to fill each type of vacant position.

Type of Vacancy	Average Time Needed to Fill Vacancies
Registered Nurse	31-60 Days
Licensed Practical Nurse	31-60 Days
Aides/Assistants	31-60 Days
Allied Health Therapists	Not Applicable

Electronic Signature

Please note that the survey WILL NOT BE ACCEPTED without the authorized signature of the Chief Executive Officer or Executive Director (principal officer) of the facility. The signature can be completed only AFTER all survey data has been finalized. By law, the signatory is attesting under penalty of law that the information is accurate and complete.

I state, certify and attest that to the best of my knowledge upon conducting due diligence to assure the accuracy and completeness of all data, and based upon my affirmative review of the entire completed survey, this completed survey contains no untrue statement, or inaccurate data, nor omits requested material information or data. I further state, certify and attest that I have reviewed the entire contents of the completed survey with all appropriate staff of the facility. I further understand that inaccurate, incomplete or omitted data could lead to sanctions against me or my facility. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act.

Authorized Signature: Pravinchandra H. Patel, MD

Date: 6/1/2009

Title: CEO- Presdient

Comments: